

**First Health Services of Montana
ADULT CRISIS STABILIZATION
Continued Stay Request Form**

First Health Services of Montana

To transmit request information:

FAX: 1-800-639-8982

PHONE: 1-800-770-3084

Mail: 4300 Cox Road

Glen Allen VA 23060

Please print or type:

PATIENT INFORMATION		
Patient Name:		
Medicaid Number:	SSN:	
MHSP Number:		
FACILITY INFORMATION		
Name:	Provider Number:	
Address:		
City:	State:	Zip Code:
Telephone Number:	Fax Number:	
Number of Days Requested:	Start Date:	
CLINICAL INFORMATION		
Any Changes in DSM-IV DIAGNOSIS:		
Code:	Narrative:	
Code:	Narrative:	
Current Mental Status:		
Justification for continued services at this level of care:		
Precautions: SP Aggression Elopement Other		

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Name Last: _____ First: _____
SSN: _____

Current Medication (include dosage and start date):

Treatment Plan/Goals:

Scheduled Activities/Groups (describe participation):

Discharge Plan (please include estimated date of discharge):

Assessment completed by:

Title:	Date:
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For First Health's Use Only:

APPROVED: From _____ Thru _____ DENIED: From _____ Thru _____
Review Date: _____ Reviewer Signature: _____